

1. WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3

CERTIFICATE OF DEATH

02910-95
Reg. Dist. No.

1. PLACE OF DEATH: Howard
 County Laurel Rural
 City or town Laurel Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 yrs.
 Hospital, Institution, or street address where death occurred: High Ridge
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Howard
 City or town Laurel Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. High Ridge
 (If rural, give LOCATION)

3. (a) FULL NAME
Rosaline H Beale

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife Clarence Beale

7. Birth date of deceased (mo., day, yr.) March 11, 1872 6. (c) If alive, give age years

8. AGE: 75 Years 0 Months 20 Days If less than one day hrs. min.

9. Birthplace Maryland North Carolina
 (Town, county and state)

10. Usual occupation Housewife

11. Industry or business Spouse

12. Name Richard King

13. Birthplace North Carolina

14. Maiden name Missouri Carolina Ballard

15. Birthplace

16. Informant Mrs. F. J. Dugay

Address 9th St. Laurel Md.

17. Burial Burial Date thereof April 3, 1947
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Dugay Hill

Location Laurel Md.

18. Funeral director High Ridge

Address Laurel Md.

19. Date rec'd by registrar 5/2/47 19 Mark Shiley

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 19 47 at 1A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31 19 47 to March 31 19 47
 and that I last saw her alive on at no time at no time 19 47

Immediate cause of death Broncho Pneumonia DURATION 1 day

Due to Influenza 3 day

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alpha W. Herbert M.D.

Deputy Medical Examiner, Howard Co.

Address Ellicott City, Md. Date signed 3/31/47

RECEIVED

APR 8 1947

BUREAU 6

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-2

CERTIFICATE OF DEATH

02917

195

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County HanoverCity or town Savage (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 80 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Savilla Frances Castle4. Sex F 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Emmanuel Martin7. Birth date of deceased (mo., day, yr.) Sept. 7 1865 6. (c) If alive, give age years8. AGE: Years 81 Months 6 Days 20 If less than one day hrs. min.9. Birthplace Savage, Hanover, Maryland (Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name Joseph Bowers13. Birthplace Anne Arundel Co., Md.14. Maiden name Elizabeth Alice Sabers15. Birthplace Baltimore, Maryland16. Informant Leitha PhelpsAddress Savage, Maryland17. Burial Burial Date thereof Mar. 30 1947 (month) (day) (year)Cemetery or crematory Savage CemeteryLocation Savage, Maryland18. Funeral director De Witt DonaldsonAddress Laurel, Maryland19. 3/29/47 19..... (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HanoverCity or town Savage (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 27th 1947 at 13¹⁰ P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17th 1947 to March 27th 1947 and that I last saw her alive on March 27 1947

Immediate cause of death

Chronic Myocardial Insuff. DURATION 1 yr.

Due to

Due to

Other conditions Common Cold DURATON 1 wk.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

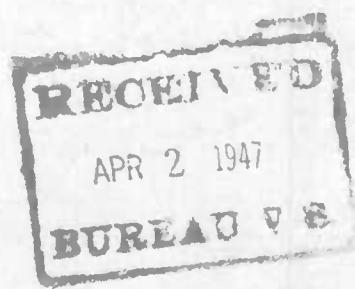
Means of injury

Injured at work?

23. SIGNATURE

Frank Shiley, M.D. M. D. or other Savage, Md. Date signed Mar. 29, 1947

Address



1-35

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ¹⁶⁶

Registered No. 193 02318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address <u>1/4 mile south of Frederick Rd.</u> (c) Hospital or institution: <u>Cooksville, Howard Co., Md.</u>		2. USUAL RESIDENCE OF DECEASED: (a) State <u>Md.</u> (b) County <u>Howard</u> (c) City or town <u>Cooksville</u> (If outside city or town limits, write RURAL and give town) (d) Street No. <u>1/4 mile south of Frederick Rd.</u> (If rural giving location) (e) Citizen of foreign country? <u>Yes or No</u> If yes, name country.	
3 (a) FULL NAME <u>Carleton Leon Dorsay</u>			
3 (b) If veteran, name war <u>None</u>		3 (c) Social Security Account No. <u>705-10-3200</u>	
4. Sex <u>Male</u>	5. Color or race <u>Colored</u>	6 (a) Single, married, widowed, or divorced. <u>Married</u>	
6 (b) Name of husband or wife <u>Jeanette</u>		6 (c) If alive, give age <u>years</u>	
7. Birth date of deceased (mo., day, yr.)			
8. AGE: Years <u>40</u>	Months <u>6</u>	Days <u>14</u>	If less than one day hr. <u></u> min. <u></u>
9. Birthplace <u>Carroll County, Md.</u> (Town, county and state)			
10. Usual Occupation <u>Farm hand</u>			
11. Industry or business <u>Canning Factory</u>			
FATHER	12. Name <u>George Dorsay</u>		
	13. Birthplace <u>Frederick Co., Md.</u>		
MOTHER	14. Maiden Name <u>Cordelia Taylor</u>		
	15. Birthplace <u>Carroll County, Md.</u>		
16 (a) Informant <u>Jeanette Dorsay</u>		(b) Address <u>Woodbine, Md.</u>	
17 (a) <u>Burial</u> (b) Date thereof <u>3/5/47</u> (Burial, cremation, or removal) (month) (day) (year)		(c) Cemetery or crematory <u>Bush Park</u> Location <u>Cooksville, Howard Co., Md.</u>	
18 (a) Funeral director <u>M. A. Murphy</u>		(b) Address <u>Mr. Murphy</u>	
19 (a) <u>3/5/47</u> (b) <u>E. Pearl Services</u> (Date rec'd by registrar)		Registrar	

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1947, at 12 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined and that the causes of death were: Bullet wound of brain

IMMEDIATE CAUSE OF DEATH Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary or contributing cause of death, fill in the following

(a) Date of injury 3/2/47 at ? M.

(b) Where did injury occur? Cooksville, Howard Co., Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Firearms - revolver

23. Signature Howard J. Melvin M.D.
Medical Examiner.

Date signed 3/2/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4-202

02919

CERTIFICATE OF DEATH

Reg. Dist. No. 1931

1. PLACE OF DEATH: Lilas W Eversly
 County Howard Co. Maryland
 City or town Rural of Florence Co. MD
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lilas W Eversly4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

8. (c) If alive, give age — years7. Birth date of deceased (mo. day, yr.) 1871. Jan 98. AGE: 76 Years 2 Months 5 Days It less than one day hrs. — min.9. Birthplace Montgomery Co. MD
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farm12. Name Unknown13. Birthplace Unknown14. Maiden name Elijah Eversly15. Birthplace —16. Informant David W EverslyAddress Woodbine MD17. Burial Burial Date thereof March 17 1947
(Burial, cremation, or removal, month (day) (year))Cemetery or crematory Altomaville MDLocation Montgomery Co. MD18. Funeral director Roy W BarkerAddress Altomaville MD19. (Date ready by registrar) 1947 E. Paul Myers2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State Maryland County Montgomery
City or town Rural of Florence Co. MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war ✓3. (b) Social Security Number ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947 at 10:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 23 1947 to March 14 1947 and that I last saw him alive on March 13 1947Immediate cause of death Paroxysm of Reckless and Intoxication DURATION 3 monthsDue to UnknownDue to —Other conditions None

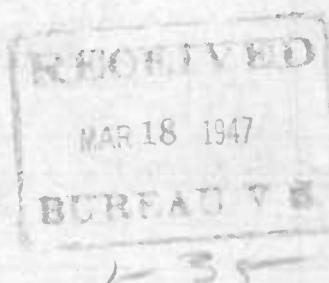
(Include pregnancy within 8 months of death)

Major findings or operations —Date of op. —Autopsy results No Autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State)Injured at home, farm, industry, public place (where?) —Means of injury —Injured at work? —23. SIGNATURE Vernon H. Dyer M. D. or other —Address Altomaville Date signed March 16 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

02921
1950

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Savage (Rural)

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 months

Hospital, institution, or street address where death occurred:

Savage Rd.

How long in hospital or institution?

3. (a) FULL NAME

Oscar E. Hawkins

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M. S. Married

6.(b) Name of husband or wife

Maudie C. Hawkins

7. Birth date of deceased (mo. day, yr.)

Dec. 18, 1877

6. (c) If alive, give age 61 years

8. AGE:

Years 69 Months 2 Days 22 It less than one day hrs. min.

9. Birthplace

Clarkburg, Montgomery, Md.

(Town, County, and state)

10. Usual occupation

Laborer

11. Industry or business

Plastic plant

12. Name

John T. Hawkins

13. Birthplace

Cayes, Maryland

14. Maiden name

Annie Thompson

15. Birthplace

Maryland

16. Informant

Maudie C. Hawkins

Address

Savage, Md.

17. Burial

Data thereof March 13, 1947

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Clarkburg Cemetery

Location

Clarkburg, Montgomery, Md.

18. Funeral director

DeMolay Donaldson

Address

Savage, Maryland

19. 312-47

19

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Savage (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. Gilford Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 10th 1947 at 10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9th 1947 to March 10th 1947 and that I last saw him alive on March 9th 1947.

Immediate cause of death

Coronary Thrombosis

DURATION

2 days

Due to ✓

Due to ✓

Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank Shiley, M.D.

M. D. or other

Address

Savage, Md. Date signed 312-47

RECEIVED

MAR 19 1947

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2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incomplete or illegible entries are especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

02920
1920

Reg. Dist. No.

1. PLACE OF DEATH:

County... Howard
City or town... West Friendship
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Asbury L. Hobbs4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Ladies Putman7. Birth date of deceased (mo. day, yr.) Oct. 24, 1888 6. (c) If alive, give age 70 years8. AGE: Years 58 Months 5 Days 6 If less than one day hrs. 00 min. 009. Birthplace Md. (Town, county, and state)10. Usual occupation Farmer11. Industry or business Agriculture12. Name Asbury L. Hobbs13. Birthplace Md.14. Maiden name Minnie D. Dorsey15. Birthplace Md.16. Informant Mrs. Ladies HobbsAddress West Friendship, Md.17. Burial Burial Date thereof April 2, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. View CemeteryLocation Howard Co., Md.18. Funeral director C. Harry NewAddress Sykesville, Md.19. Date rec'd by registrar April 1, 1947 Alice W. Hobbs
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HowardCity or town West Friendship
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1947 at 4 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-21 1947 to 3-30 1947, and that I last saw him alive on 3-30 1947.Primary cause of death Pulmonary edema DURATION UnknownDue to Alcoholism, acute UnknownDue to Had been drinking for about three months.Other condition Unknown

(Include pregnancy within 3 months of death)

Major findings or operations _____ Date of op. _____

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

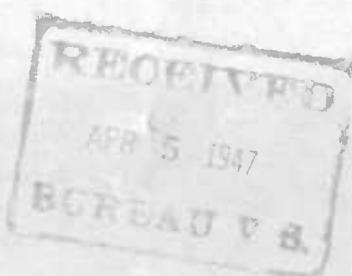
Accident, suicide, or homicide. Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work? _____

23. SIGNATURE J. H. Barnes M.D. M. D. or other _____Address Hy Russell Rd. Date signed 3/31/47



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 450

02922

CERTIFICATE OF DEATH

Reg. Distr. No.

1950

1. PLACE OF DEATH:

County Maryland

City or town Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Lester Jones

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. W. Married

6. (b) Name of husband or wife

Sarah R. Jones

7. Birth date of

deceased (mo., day, yr.) Jan 10, 1881

6. (c) If alive, give age

years

8. AGE:

Years	Months	Days	If less than one day
66	2	12	hrs. min.

9. Birthplace

Baltimore County, Md.

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Construction

MOTHER FATHER

12. Name John A. Jones, Sr.

13. Birthplace

Maryland

14. Maiden name

Martha Jane Remmey

15. Birthplace

Maryland

16. Informant

Maryland Jones

Address

Savage, Maryland

Cremation

Date thereof Jan 25, 1947

(month) (day) (year)

Cemetery or crematory

Fair Lincoln Cemetery

Location

Maryland

18. Funeral director

A. L. D. Funeral Home

Address

Savage, Maryland

Frank Shirley

Signature

3/24/47 19

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23rd 1947 at 8 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 12 1947 to Mar 22nd 1947and that I last saw him alive on Mar 20th 1947

Immediate cause of death

Carcinoma of Tongue

DURATION

9 mos.

Due to

✓

Due to

✓

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank Shirley, M.D.

M. D. or other

Address Savage, Md. Date signed 3/24/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466

02923

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County Howard
 City or town Elkridge
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

6118 old wash Rd.

How long in hospital or institution?

3. (a) FULL NAME

George chauncey Laynor

3. (b) Social Security Number

none

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Married

8. (b) Name of husband or wife

Sadie BrownLaynor 6. (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.)

Nov 2 18908. AGE: Years 76 Months 4 Days 21 If less than one dayhrs. min.9. Birthplace Baltimore city
(Town, county, and state)10. Usual occupation Merchant11. Industry or business Retired12. Name See C Laynor13. Birthplace Baltimore Md14. Maiden name Mariam Heming15. Birthplace Baltimore Md16. Informant Mrs Sadie Laynor wifeAddress 6118 old wash Rd Elkridge17. Burial Date thereof 3/27/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Meadowood Memorial CrLocation Elkridge Md18. Funeral director John L. Brown & SonAddress 901-03 Hollins St. - 1319. Date rec'd by registrar March 25 47 A. W. Hedrich
(Date rec'd by registrar) A. W. Hedrich
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HowardCity or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 6118 old wash Rd.
(If rural, give LOCATION)2.(a) If veteran, name war none

MEDICAL CERTIFICATION

2D. DATE OF DEATH

March 24 19471946 to March 24 1947and that I last saw him alive on March 23 1947

Immediate cause of death

Myocardialcircumferenceenlargement ofstomachDue to general arterioclerosisOther conditions Senility

DURATION

3 mo6 mo1 yr

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Elkridge Md Date signed 3/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

02924

193

Reg. Dist. No.

1. PLACE OF DEATH: Howard
 County Rural - Daisy
 City or town. (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 46 yrs.
 Hospital, institution, or street address where death occurred: _____
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Howard County Frederick
 City or town. (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____ (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME Enos Lee Main

3. (b) Social Security Number None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
Susie E. Shunkle Main
 6. (b) Name of husband or wife Susie E. Shunkle Main
 8. (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) 1-19-1863

8. AGE: Years 84 Months 7 Days 0 If less than one day _____ hrs. _____ min.

6. Birthplace Frederick Co. Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Elwood Mayne
 13. Birthplace Frederick Co. Md.

MOTHER 14. Maiden name Annie Eagle
 15. Birthplace Frederick Co. Md.

18. Informant Mrs. Enos L. Main

Address Daisy - Maryland

17. Burial Rocky Springs Date thereof 3-21-1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rocky Springs
 Location West of Frederick - Md.

18. Funeral director C. E. Cline & Son

Address Frederick - Md.

19. 3/21/1947 E. Paul Main
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1947 at 5:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 1947 to Mar. 19 1947 and that I last saw him alive on March 18 1947

Immediate cause of death

Hemiplegia (right) DURATION 3 da

Due to Advanced arterio-sclerosis ? yrs

Due to

Other conditions Uremia - ch. DURATION ?

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

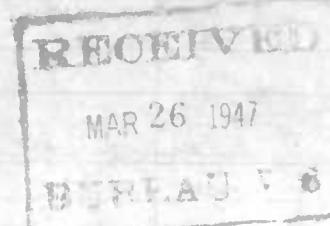
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Stanley Grabill - M.D. M. D. or other _____

Address Maryland - Date signed 3/19/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

★ cb 02925
Reg. Dist. No. 191

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Washington Blvd., 2 mi south of
Waterloo Road

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Cpl Lt Masters Personal Affairs

division

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

Murry McCarty

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White

Divorced

8. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

March 27, 1896

6. (c) If alive, give age..... years

8. AGE:

Years Months Days If less than one day

50

11

25

hrs.

min.

9. Birthplace.....

King George Co., Va.

(Town, county, and state)

10. Usual occupation.....

Soldier (Discharged)

U.S. Army

11. Industry or business.....

LAMUEL McCARTY

12. Name

MOTHER FATHER

King GEORGE Co. VA

13. Birthplace

Alice JONES

14. Maiden name

King GEORGE Co. VA

15. Birthplace

Family RECORD

16. Informant

809 PRINCESS ST. ALEXANDRIA, VA.

Address

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof MARCH 25 1947

(month) (day) (year)

Cemetery or crematory

ARLINGTON NATIONAL

Location

ARLINGTON VIRGINIA

18. Funeral director

J.C. Kelly's Suburbans

Address

Ebens City MD

19. Date rec'd by registrar

1947

(Date rec'd by registrar)

John B. Longman
P.A.B.E. & Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 22, 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 22, 1947, to March 22, 1947

and that I last saw him alive on at no time

Immediate cause of death

Compound fracture of skull at

base of brain

DURATION

1 min.

Due to

Automobile accident

Other conditions

Compound fracture of both legs below knee

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

accident Date of

Where did injury occur

Waterloo Howard MD

(City or town) (County) (State)

Injured at home, farm, industry, public place, (where?)

Highway

Means of injury auto accident

Injured at work?

Alpha N Herbert MD

DEPUTY MEDICAL EXAMINER M.D. or other

Baltimore City MD Date signed

3/22/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 552

CERTIFICATE OF DEATH

02926

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

1. PLACE OF DEATH:

County..... *Howard*
 City or town..... *Elkridge*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6330 old Washington Rd.

How long in hospital or institution?

3. (a) FULL NAME

*Katherine Agnes Moller*4. Sex *Female* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *married*8. (b) Name of husband or wife *John H. Moller*7. Birth date of deceased (mo., day, yr.) *Jan 20 1965*8. AGE: Years *82* Months *1* Days *26* It less than one day *hrs. min.*9. Birthplace *Elkridge Rd*
(Town, county and state)10. Usual occupation *housewife*

11. Industry or business

12. Name *Michael Morris*13. Birthplace *Cleveland*14. Maiden name *Bridget Gibbons*15. Birthplace *Cleveland*16. Informant *Mrs. T. L. Bush (daughter)*Address *Elkridge Rd*17. Burial *Burial* Date thereof *3/20/47*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *St. Augustine's Cemetery*Location *Elkridge, Md.*18. Funeral director *John J. Cowan & Son*Address *901-03 Hollins St.*

19. 3-18 1947 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Md* County..... *Howard*City or town..... *Elkridge*
 (If outside city or town limits, write RURAL and give nearest town)Street No..... *6330 old Wash Rd*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH *Mar 18 1947*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Aug 1946 to Mar 18 1947*and that I last saw him *alive* on *Mar 18 1947*Immediate cause of death *Coronary**Ischaemic**Cardiomegaly**Stomach**Senility*Other conditions *-*

DURATION

*1 yr.**2 mo.*

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE *B. B. Grumbrough*

M. D. or other

Address *Elkridge Rd* Date signed *3/18/47*

Registrar

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

02927

CERTIFICATE OF DEATH

Reg. Dist. No. 1926

PLEASE WRITE PLAINLY, WITH ~~INK~~ ~~ADADING INK~~. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

Glenelg

City or town

Glenelg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

4 mos

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Florence Isabelle Powell

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Mar. 4, 1946

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

4

0

hrs.

min.

9. Birthplace

Glenelg, Md.

(Town, county, and state)

10. Usual occupation

House

11. Industry or business

Edward Powell

12. Name

Edward

13. Birthplace

Md.

14. Maiden name

Florence I. Young

Md.

15. Birthplace

Edward

16. Informant

Edward Powell

Address

Glenelg, Md.

17. Burial

Burial

Date thereof (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Brook Park

Location

Glenwood, Md.

18. Funeral director

J. H. Higginbotham

Address

Ebens City, Md.

19. March 5, 1947

Alice D. Holt

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Glenelg

(If outside city or town limits, write RURAL and give nearest town)

Street No. McTendee Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 4, 1947, at 3A

21. CERTIFY that death occurred on the date above stated: that I attended deceased from March 4, 1947, to March 4, 1947, and that I last saw him alive on at no time.

Immediate cause of death

Abras. Pneumonia 2 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

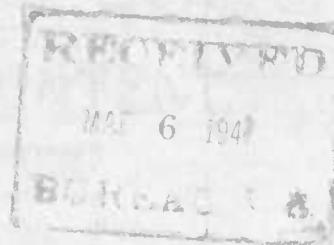
Means of injury

Injured at work?

23. SIGNATURE

DEPUTY MEDICAL EXAMINER FOR HOWARD COUNTY, or other

Address Elmer A. Herbert, M.D. Date signed 3-447



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

02928
Reg. Dlat. No. 195

1. PLACE OF DEATH: Howard
 County Jessup Rural
 City or town Jessup (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 84 years
 Hospital, institution, or street address where death occurred: Watertown
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Howard
 City or town Jessup (If outside city or town limits, write RURAL and give nearest town)
 Street No. Dear Waterloo (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Frederick Walter Rowe

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) July 24, 1862 6.(c) If alive, give age years

8. AGE: Years 84 Months 7 Days 9 If less than one day hrs. min.

9. Birthplace Jessup Md. (Town, county, and state)

10. Usual occupation Labourer

11. Industry or business

12. Name Thomas Rowe
 MOTHER FATHER

13. Birthplace Maryland
 MOTHER

14. Maiden name Mary Belwette
 15. Birthplace Gloucester England

16. Informant Mrs. Helen Rowe
 Address Baltimore, Md.

17. Burial Burial Date thereof March 2, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Chapel Hill Cemetery

Location Jessup, Md.

18. Funeral director Easton Sons
 Address Ellicott City, Md.

19. 3/6/47 (Date rec'd by registrar) 19 Frank Shigley (Signature)
 Address Savage, Md. M. D. or other Frank Shigley
 Date signed 3/8/47

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 2, 1947

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 2, 1947 to March 2, 1947

and that I last saw him alive on March 2, 1947

Immediate cause of death Myocardial comp. DURATION 2 days

Due to —

Due to —

Other conditions Senility DYP

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

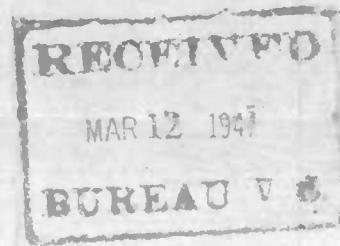
Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work —

23. SIGNATURE Frank Shigley M. D. or other Frank Shigley
 Address Savage, Md. Date signed 3/8/47



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

02929

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH:
County..... Howard

City or town..... Highland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 minutes

Hospital, institution, or street address where death occurred:

in automobile enroute to hospital

How long in hospital or institution?..... - - - - -

3. (a) FULL NAME
EDWARD LEE SIMPSON

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

8. (b) Name of husband or wife..... - - - - -

7. Birth date of deceased (mo., day, yr.) October 3, 1946
(Town, county, and state)

8. AGE: Years Months Days If less than one day
5 8 hrs. min.

9. Birthplace..... Ashton, Maryland
(Town, county, and state)

10. Usual occupation..... infant

11. Industry or business

MOTHER FATHER 12. Name..... Charles E. Simpson
13. Birthplace..... Maryland

MOTHER 14. Maiden name..... Marjorie Beall
15. Birthplace..... Maryland

16. Informant..... Charles E. Simpson
Address..... Dayton, Md.

17. burial..... Date thereof..... 3-14-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Linthicum Chapel
Location..... Dayton, Md.

18. Funeral director..... F. C. Higinbotham
Address..... Ellicott City, Md.

19. 3-12 1947
(Date rec'd by registrar) Marie A. Wheeler
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Howard
City or town..... Dayton
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2. (a) If veteran, name war..... - - - - -

3. (b) Social Security Number
- - - - -

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 11 1947 at 10:15 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 3 1946 to March 11 1947

and that I last saw him alive on March 11 1947

Immediate cause of death..... Bronchopneumonia
DURATION 3 days

Due to.....

Due to.....

Other conditions..... pemphigus neonatorum 5 mos
malnutrition 4 mos
(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

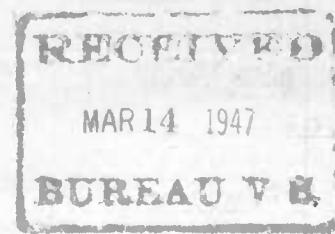
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Charles S. Whitaker, M.D.
M. D. or other

Address..... Clarksville, Md. Date signed 3-11-47



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

02930

CERTIFICATE OF DEATH

1950

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 County Anne Arundel Hospital
 City or town Annapolis Junction
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Anne Arundel
 City or town Annapolis Junction
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME
 VALENTINE G. SPINDLER

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>	
6.(b) Name of husband or wife <u>Lena M. Spindler</u> <u>(nee. Drieslien)</u>			
7. Birth date of deceased (mo., day, yr.) <u>April 23, 1877</u>			
8. AGE: Years <u>69</u>	Months <u>10</u>	Days <u>27</u>	If less than one day hrs. _____ min. _____
9. Birthplace <u>Germany</u> <small>(Town, county, and state)</small> <u>Canner & Farmer</u>			
10. Usual occupation <u>Farming</u>			
11. Industry or business <u>Farming</u>			
MOTHER FATHER	12. Name <u>A. P. Spindler</u>	13. Birthplace <u>Germany</u>	
MOTHER	14. Maiden name <u>Catherine Walter</u>	15. Birthplace <u>Germany</u>	
16. Informant <u>Mr. M. L. Henkel, Son-in-Law</u> Address <u>Annapolis Junction, Md.</u>			
17. Burial <u>Burial</u> Date thereof <u>3/24/47</u> <small>(Burial, cremation, or removal. Which?)</small> (month) (day) (year) Cemetery or crematory <u>Loudon Park Cem.</u> Location <u>Balto., Md.</u>			
18. Funeral director <u>WM. J. TICKNER & SONS</u> Address <u>Balto., Md.</u>			
19. Date rec'd by registrar <u>3/21/47</u> 19 _____			

3. (b) Social Security Number
 no

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1947 at 5 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st to March 20, 1947 and that I last saw him alive on March 15th 1947.

Immediate cause of death Coronary Embolism

Due to Myocardial Insuff. - DURATION Instant.

Due to Arterio-Sclerosis DURATION 3 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank Shiley, M.D.
 M. D. or other Savage, Md. Date signed 3/21/47
 Address



2-35-

1
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

53

02932

CERTIFICATE OF DEATH

Reg. Dist. No. 1940

1. PLACE OF DEATH:

County..... Howard
City or town..... Clarksville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Githers Talbott

4. Sex..... m 5. Color or race..... w 6. (a) Single, married, widowed, or divorced..... Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... June 13, 1925

8. AGE: Years..... 21 Months..... 8 Days..... 20 If less than one day..... hrs..... min.....

9. Birthplace..... Baltimore, Md.

10. Usual occupation..... Student

11. Industry or business.....

12. Name..... Wm E Talbott

13. Birthplace..... Md.

14. Maiden name..... Lenore Dorsey

15. Birthplace..... Md

16. Informant..... Wm E Talbott

Address..... Clarksville, Md.

17. Burial..... Date thereof..... 3-5-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St Johns

Location..... Ellicott City, Md.

18. Funeral director..... J.C. Negusbotham

Address..... Ellicott City, Md.

19. 3-4-47 (Date rec'd by registrar)..... Marie C. Whitaker
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Howard
City or town..... Clarksville
(If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 3, 1947, at..... 11A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 11, 1946, to March 3, 1947, and that I last saw him alive on March 3, 1947.

Immediate cause of death..... Melanoma right ear with metastases to brain

DURATION

4 years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

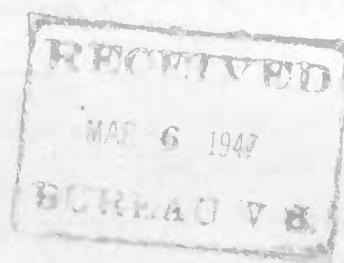
Means of injury..... Injured at work?

23. SIGNATURE..... Charles S. Wintzler, M.D.

M.D. or other

Address..... Clarksville, Md. Date signed..... 3-4-47

AMERICAN LIBRARY
ASSOCIATION



1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

02931

1950

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Howard

Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. W. Divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Mar 25, 1875

8. AGE:

Years

Months

Days

If less than one day

71 11 27 hrs. min.

9. Birthplace

New Windsor Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farm

Martin Shaddell

12. Name

Martin Shaddell

13. Birthplace

Md.

Unknown

14. Maiden name

Mrs. Lillian Worcester

15. Birthplace

Baltimore Md.

Date thereof May 26, 1897

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory

Savage Md.

Location

Savage Md.

16. Funeral director

John W. McDonald

Address

Loudon Md.

17. Date rec'd by registrar

31/25/47 19

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Howard

City or town

Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

218-05-9099

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 22 1947 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1946 to March 22 1947

and that I last saw him alive on March 22 1947

Immediate cause of death: Chronic myocarditis

DURATION

3 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

none

Date of op.

Autopsy results:

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert S. McConney Jr.

M. D. or D.V.M.

Address

Layton Md.

Date signed

3/25/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

02933

CERTIFICATE OF DEATH

Reg. Dist. No. 191-1950

1. PLACE OF DEATH:

County HowardCity or town Emmetsfield (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 yrs.Hospital, institution, or street address where death occurred: Jessup, Md.

How long in hospital or institution?

3. (a) FULL NAME

CHARLES H. WALLICH

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m w widower

6. (b) Name of husband or wife

Ella May Wallich

7. Birth date of deceased (mo., day, yr.)

July 21, 1876.6. (c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

70 7 24 hrs. min.

9. Birthplace

(Town, county, and state) Emmetsfield

10. Usual occupation

Retired

11. Industry or business

Emmetsfield Wallich

FATHER

12. Name

13. Birthplace

Emmetsfield

14. Maiden name

Catherine Bumpson

MOTHER

15. Birthplace

Emmetsfield

16. Informant

Wm Wallich

Address

Emmetsfield City Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 3-18-47 (month) (day) (year)

Cemetery or crematory

St. Mark's

Location

Highland, Md.

18. Funeral director

J.P. Longman

Address

Emmetsfield City Md.19. Death date Dec 21, 1947

(Date rec'd by registrar)

John P. Longman
Per. B. E. S. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County HowardCity or town Emmetsfield

(If outside city or town limits, write RURAL and give nearest town)

Street No. JessupR. # 74

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 15 1947 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 10 1946 to March 12 1947and that I last saw him alive on March 12 1947Immediate cause of death Myocardial insufficiencyto pulmonary edemaanasarcaDue to Chronic MyocarditisDue to ArteriosclerosisOther conditions Sinus tachycardia

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE

John Stevens M.D.

M. D. or other

Address Glenelg, Maryland Date signed 3/15/47

